RETURN THIS FORM TO THE STUDY AWAY OFFICE WITH PRE-DEPARTURE MATERIALS

EMAIL: studyaway@williams.edu

MAIL: Williams College, Study Away Office, PO Box 518, Williamstown, MA 01267

OFF-CAMPUS HEALTH COVERAGE VERIFICATION

Please note: The College provides for every student, staff, and faculty member traveling on College sanctioned travel insurance to cover emergency medical situations. This coverage is in addition to your regular health insurance. Please consult with your health insurance provider to determine what level of coverage you have for purposes of regular medical maintenance needs that you might require while traveling abroad. The College emergency medical insurance noted above does not provide coverage for routine medical procedures.

_____ _____ _____

Student Name *Class Year* *Williams I.D. #*

I certify that:

1. I will be enrolled in the following health insurance program from ___/___/___ to ___/___/___

   Insurance Company _____

   Policy Identification Number _____

   Policy Subscriber's Name _____

   Policy Subscriber's Relationship to Student _____

2. I have examined this insurance policy and have determined that it will cover my medical expenses while I am studying outside the territory of the United States.

3. I understand that I will be responsible for my own medical expenses while away.

   From ____/____/____ to ____/____/____ (date of departure and date of return)

_____ Date: _____

Signature

Note: All Williams students must have medical coverage.

December 2016